STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395448	A. BLDG: 00 B. WING:	04/28/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BUCKTAIL MEDICAL CENTER STATE LICENSE NUMBER: **549602**	**1001 PINE STREET** **RENOVO, PA 17764**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, and Civil Rights Compliance Survey, completed on April 28, 2023, it was determined that Bucktail Medical Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0607 SS=D		F 0607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0607 SS=D	Continued from page 1 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	Employee #2 & 6 references were called, and references verification added to files. Abuse education provided for employee #3 March 9, 2023, and employee #4 March 9, 2023. All New hires over the past three months will be reviewed for completion of references. Reference checks will be completed on any employees without completed reference checks. Reference checks and education for abuse and neglect were added to the pre-employment checklist. Bothe the Director of nursing and administrative secretary will monitor all new employee applications for reference checks and abuse education on or before the first day of work. Follow through with obtaining references and completion of abuse education has been added as a Quality Indicator (QI) for the facility	Completion Date: **05/19/2023** Status: **APPROVED** Date: **05/11/2023**

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F 0607 SS=D	Continued from page 2 This REQUIREMENT is not met as evidenced by:	F 0607	Quality Assurance (QA) program. The Director of Nursing (DON) or her designee and administrative secretary will monitor the completion of new hire checklist until 100% compliance is maintained for six (6) months at which time the audits will be random. The DON will report outcomes of the audits monthly at the QA meeting.	

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F 0607 SS=D	Continued from page 3 Based on review of select facility policies, employee personnel records, and staff interview, it was determined that the facility failed to develop and implement an abuse prohibition policy that required a thorough investigation of prospective employee's employment history for four of five newly hired employees reviewed (Employees 2, 3, 4, and 6). Findings include: The policy entitled "Abuse Prevention, Recognition, Reporting, and Investigating" last reviewed without changes on January 25, 2023, revealed that residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and Involuntary seclusion. The facility will provide staff education regarding recognition and assessment of potential abuse and documentation of findings. The policy did not indicate that prior to the offer of employment, the facility will obtain reference information from past or current employers and/or personal references or, alternatively, documentation of attempts to obtain	F 0607		

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F 0607 SS=D	Continued from page 4 such reference information. Review of Employee 2's, nurse aide, personnel record revealed that the facility hired them on December 30, 2022. Employee 2's personnel record did not reveal any evidence that a facility representative attempted to obtain reference information from a former employer and/or current employer or personal references. Review of Employee 3's, housekeeping, personnel record revealed that the facility hired them on December 27, 2022. Employee 3's personnel record revealed that the facility provided abuse education on March 9, 2023, 72 days after being hired, and after Employee 3 had access to residents. Review of Employee 4's, maintenance, personnel record revealed that the facility hired them on January 24, 2023. Employee 4's personnel record revealed that the facility provided abuse education on March 9, 2023, 44 days after being hired, and after Employee 4 had access to residents.	F 0607		

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F 0607 SS=D	Continued from page 5 Review of Employee 6 's, maintenance, personnel record revealed that the facility hired them on December 30, 2022. Employee 6's personnel record did not reveal any evidence that a facility representative attempted to obtain reference information from a former employer, a current employer, or personal references. This surveyor reviewed this information during an interview with the Director of Nursing on April 28, 2023, at 10:50 AM. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.19 Personnel policies and procedures	F 0607		
F 0697 SS=D		F 0697		

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F 0697 SS=D	Continued from page 6 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0697	Policy "Medication: Pain Management" was updated from mild moderate and severe to include associated 1-10 scale based on the currently used number pain scale and PAINAD scale. All current PRN orders were reviewed, and directives of use of PRN medication based on the 1-10 scales was included. All RN and LPN staff will be educated on the update policy "Medication: Pain Management" Monitoring of the physician orders for PRN administration of pain medication based on the obtained score (1-10 on pain scale) and follow through of the administering nurse providing the appropriate PRN based on the pain scale will be completed by the Director of Nursing or designee. Proper physician ordering and administration of PRN pain medication has been added as a Quality Indicator (QI) for the facility Quality Assurance (QA) program.	Completion Date: **05/19/2023** Status: **APPROVED** Date: **05/10/2023**

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F 0697 SS=D	Continued from page 7	F 0697	The Director of Nursing (DON) or her designee will monitor the PRN pain medication orders and administration weekly until all documentation and administration is at 100% for four (4) weeks then monitoring will be monthly until six (6) months at 100% at which time the audits will be random. The DON will report outcomes of the audits monthly at the QA meeting.	

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F 0697 SS=D	Continued from page 8 Based on review of select facility policies, clinical record review, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered pain medications for one of two residents reviewed (Resident 19). Findings include: The facility policy entitled, "Administering Pain Medications," last reviewed without changes on January 25, 2023, revealed that the facility will utilize standardized pain assessment tools including the 10 point pain intensity scale. Review of Physiopedia's and Wikipedia's definition of the numeric pain rating scale from zero to 10 indicated that no pain was identified as zero, mild pain was identified as one to three, moderate pain was identified as four to six, and severe pain was identified as seven to 10. Clinical record review for Resident 19 revealed	F 0697		

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F 0697 SS=D	Continued from page 9 physician's orders for the following pain medications: Ordered on September 14, 2022, and discontinued on March 29, 2023, Acetaminophen (Tylenol, for pain) 500 milligrams (mg) by mouth (PO) every 8 hours as needed (PRN) for pain, not to exceed 4 Grams in 24 hours. Ordered on March 24, 2023, and discontinued on March 29, 2023, Tramadol (for pain) 50 mg PO every 6 hours PRN for breakthrough severe pain. Review of Resident 19's March 2023 MAR (medication administration record, a form to document medication administration) revealed that staff administered the following PRN pain medicatons: March 27, 2023, at 5:05 PM, Acetaminophen 500 mg 2 tablets PO every 8 hours PRN for a pain level of 6. March 27, 2023, 5:05 PM, Tramadol 50 mg one	F 0697		

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F 0697 SS=D	Continued from page 10 tablet PO every 6 hours PRN for breakthrough severe pain for a pain level of 6. Staff did not administer Resident 19's pain medications according to the physician ordered pain scale level(s) nor did they identify the overlapping medication pain administration scales and administered both Acetaminophen and Tramadol on the same day and same time for moderate pain. The surveyor reviewed Resident 19's pain information during an interview with the Nursing Home Administrator and Director of Nursing on April 26, 2023, at 2:00 PM. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0697		
F 0712 SS=D		F 0712		

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F 0712 SS=D	Continued from page 11 483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 0712	Physician were alerted and complete visits on all residents needing to be seen. Resident #2 was seen by physician 4/27/23, Resident #5 was seen by physician on 4/13/23, and resident #19 was seen by physician on 4/27/23. Because of the transition to a new medical director, all current residents have been seen by the physician in April 2023. Moving forward the Registered Nurse Assessment Coordinator (RNAC) has prepared and will maintain a list of residents needing seen by physician/nurse practioner. The Director of Nursing and/or RNAC will maintain this list, updating as needed. Timely physician visits have been added as a Quality Indicator (QI) for the facility Quality Assurance (QA) program. The Director of Nursing (DON) or her designee will monitor physician visits ensuring all residents are seen at the 30-60-90-day intervals and alternating between the physician	Completion Date: **05/19/2023** Status: **APPROVED** Date: **05/11/2023**

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F 0712 SS=D	Continued from page 12	F 0712	and Nurse Practioner. Audits will occur monthly until 100% compliance for six (6) months.	

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F 0712 SS=D	Continued from page 13 Based on clinical record review and staff interview, it was determined that the facility failed to ensure timely physician visits for 3 of 12 residents sampled (Residents 2, 5, and 19). Findings included: Clinical record review for Resident 2 revealed a physician completed a visit on July 10, 2022. There was no documentation that a physician or a physician's assistant completed another visit until February 3, 2023, seven months later. There was no documentation of timely physician visits every 60 days as required. Clinical record review for Resident 5 revealed a physician completed a visit on September 15, 2022. The next physician visit was on December 9, 2022, 92 days later. There was no documentation of a timely physician visit every 60 days as required. Clinical record review for Resident 19 revealed that she was initially admitted on September 8, 2022,	F 0712		

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F 0712 SS=D	Continued from page 14 admitted to the hospital on September 21, 2022, then readmitted to the facility on September 30, 2022. A physician's assistant completed a visit on the following dates: October 17, 24, and 25, 2022 November 16, 18, 23, and 28, 2022 January 13, 2023 A physician visited Resident 19 on March 10, 2023, 6 months after her initial admission to the facility. There was no documentation indicating that a physician completed a physician visit for Resident 19 prior to March 10, 2023. There was no documented evidence that the physician completed an initial visit and every 30 days for the first 90 days after admission as required. This surveyor reviewed this information with the Director of Nursing on April 27, 2023, at 10:10 AM. The Director of Nursing acknowledged that	F 0712		

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F 0712 SS=D	Continued from page 15 the physician visits were not timely. 28 Pa. Code 201.18 (e)(3) Management 28 Pa. Code 211.2 (a)(d)(2) Physician services 28 Pa. Code 211.5(f)(h) Clinical records	F 0712		
F 0812 SS=D		F 0812		

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F 0812 SS=D	Continued from page 16 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	Boxes on the floor of the walk-in freezer were moved onto shelving in the unit. Dietary staff will be educated about proper storage of food items in the walk-in cooler and freezer. Proper storage of food items in the walk-in cooler and freezer has been added as a Quality Indicator for the Quality Assurance program. Dietary manager will monitor the walk-in cooler and freezer on a daily basis for proper storage of food items and document findings. Dietary manager will report findings at the monthly Quality Assurance meeting. Monitoring and reporting will continue until 100% compliance is attained and maintained for three (3) consecutive months, and will then move to random monitoring. Damaged ceiling tiles in the dish room and dry storage have been replaced.	Completion Date: **05/26/2023** Status: **APPROVED** Date: **05/10/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395448	A. BLDG: __00_____ B. WING: _____	04/28/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BUCKTAIL MEDICAL CENTER STATE LICENSE NUMBER: **549602**	**1001 PINE STREET RENOVO, PA 17764**

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F 0812 SS=D	Continued from page 17	F 0812	Monitoring for damaged ceiling tiles in the kitchen areas has been added as a Quality Indicator for the Quality Assurance program. Dietary manager will survey the dish room and dry storage for ceiling tile damage on a weekly basis for damage and document findings. Dietary manager will report findings at the monthly Quality Assurance meeting. Surveying and reporting will continue until 100% compliance is attained and maintained for three (3) consecutive months, and will then move to random monitoring. The rusted vent was removed, sanded, painted, and replaced. Monitoring for damaged/rusting vents in the kitchen areas has been added as a Quality Indicator for the Quality Assurance program. Dietary manager will survey the kitchen areas for damaged/rusted vents on a weekly basis and	

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F 0812 SS=D	Continued from page 18	F 0812	document findings. Dietary manager will report findings at the monthly Quality Assurance meeting. Surveying and reporting will continue until 100% compliance is attained and maintained for three (3) consecutive months, and will then move to random monitoring. Covers were placed on fluorescent lights in the dish room and bulbs were replaced. Monitoring for damaged lighting in the kitchen areas has been added as a Quality Indicator for the Quality Assurance program. Dietary manager will survey the kitchen areas for damaged lighting on a weekly basis and document findings. Dietary manager will report findings at the monthly Quality Assurance meeting. Surveying and reporting will continue until 100% compliance is attained and maintained for three	

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F 0812 SS=D	Continued from page 19	F 0812	(3) consecutive months and will then move to random monitoring.	

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F 0812 SS=D	Continued from page 20 Based on observation and staff interview, it was determined that the facility failed to store and prepare food in a safe and sanitary environment in the facility's main kitchen. Findings include: An observation of the facility's main kitchen on April 25, 2023, at 11:00 AM with Employee 1, dietary manager, revealed the following: Two boxes of chicken were observed stored directly on the floor in the walk-in freezer. A ceiling tile was observed in the corner of the dry storage room with multiple dried brown stains, above shelving where food products were stored. Multiple ceiling tiles in the dish washing area were observed above the dish machine to be significantly brown stained and bulging in several spots with the appearance of dried liquid damage. A metal vent in the ceiling in the same area was rusted with dried	F 0812		

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F 0812 SS=D	Continued from page 21 brown stains surrounding the vent on the ceiling Two rows of fluorescent lighting were observed in the dish washing room. There was no cover over one set of two long bulbs, and no cover over another containing only one long bulb with the other missing, leaving the fluorescent bulbs exposed with potential for physical contaminants upon breakage. Employee 1 indicated the light fixtures and stained ceiling tiles had been there for some time but could not indicate how long. The above information was reviewed with the Nursing Home Administrator on April 26, 2023, at 1:00 PM he was aware of water leaks in the building and was awaiting approval of a roof replacement. 28 Pa. Code 211.6 (c) Dietary services	F 0812		
F 0842 SS=E		F 0842		

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F 0842 SS=E	Continued from page 22 483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Assessments for residents 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14, and 19 will be reviewed, signed, and locked by signed and locked as needed by Medical Doctor (MD) and Physician Assistant (PA) no later than 05/12/2023. All assessments for remaining residents were reviewed and all had unsigned and/or unlocked assessments. Assessments for all remaining residents will be signed and/or locked as needed no later than 05/12/2023. On initial investigation, locking assessments did not prohibit amendments or edits. PCC technical support was able to demonstrate how to adjust settings to keep them from being altered once locked. This adjustment was made so that once any assessment is locked, it cannot be changed. MD and PA were educated on the need to sign and lock all "Assessments Medical Visits".	Completion Date: **05/26/2023** Status: **APPROVED** Date: **05/11/2023**

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	395448	A. BLDG: __00_____ B. WING: _____	04/28/2023

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F 0842 SS=E	Continued from page 23 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842	The Director of Nursing (DON) or designee will monitor the signing and locking of "Assessments Medical Visits" for compliance. Signing of and locking of "assessments medical visits has been added as a Quality Indicator (QI) for the facility Quality Assurance (QA) program. The Director of Nursing (DON) or her designee will monitor physician signing and locking of "Assessment Physician Visits" Audits will occur monthly until 100% compliance for six (6) months.	

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	395448	A. BLDG: __00_____ B. WING: _____	04/28/2023

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F 0842 SS=E	Continued from page 24 This REQUIREMENT is not met as evidenced by:	F 0842		

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STATE LICENSE NUMBER: **549602**	

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F 0842 SS=E	Continued from page 25 Based on clinical record review, review of facility documents, and staff interview, it was determined that the facility failed to maintain complete and accurate clinical documentation for 12 of 12 residents reviewed (Residents 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14, and 19). Findings include: Clinical record review for Resident 4 revealed medical visit notes in point click care (PPC the facility' computerized documentation system) for the dates of January 12, 2023, and March 15, 2023, that were still in progress and not locked by the physician's assistant. Further clinical record review for Resident 4 revealed a medical visit note dated March 6, 2023, that was not signed or locked by the attending physician. Clinical record review for Resident 7 revealed medical visit notes in PCC for the dates of December 9, 2022, and April 13, 2023, that were still in progress and not locked by Resident 7's	F 0842		

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F 0842 SS=E	Continued from page 26 attending physician. Further clinical record review revealed progress notes dated February 2, 2023, and January 13, 2023, that were still in progress and not locked by the physician's assistant. Clinical record review for Resident 8 revealed medical visit notes in PCC for the dates of February 26, 2023, that was still in progress and not signed or locked by the attending physician. Resident 8 also had a medical visit note dated April 13, 2023, that was still in progress and not locked by the attending physician. Further clinical record review revealed progress notes dated December 14, 2022, and March 14, 2023, that were still in progress and not signed by the physician's assistant. Clinical record review for Resident 10 revealed a medical visit note in PCC for the date of March 8, 2023, that was still in progress and not signed or locked by the resident's attending physician. Further clinical record review revealed medical visit notes dated November 28, 2022, and December 30, 2022, that were still in progress and were not	F 0842		

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	395448	A. BLDG: 00 B. WING:	04/28/2023

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F 0842 SS=E	Continued from page 27 locked by the physician's assistant. Interview with the Director of Nursing on April 28, 2023, at 9:30 AM revealed that progress notes that are not signed and/or locked and still in progress have the potential to be edited by staff that have access to PCC. Electronic clinical record review for Resident 14 revealed medical visits, in the assessment section of the resident's electronic clinical record. A medical visit dated February 3, 2023, was created, and revised by the physician's assistant, a medical visit dated April 10, 2023, was created, and revised by the attending physician. Both medical visits remained "in progress," and although signed, they were not locked in the electronic record. Clinical record review for Resident 12 revealed medical visits in the resident assessments dated December 9, 2022, and April 10, 2023, were created, and revised by the physician, and a medical visit dated February 3, 2023, created and revised	F 0842		

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F 0842 SS=E	Continued from page 28 by the physician's assistant, were still "in progress." The documents were signed, but not locked in the electronic clinical record. Clinical record review for Resident 9 revealed medical visit assessment documentation on January 13, 2023, created, and revised by the physician's assistant, was signed, but not locked, and a medical visit dated April 10, 2023, created and revised by the attending physician was not signed or locked, and both remained "in progress." Clinical record review for Resident 3, revealed medical visits in the assessment section of the resident's electronic clinical record dated December 12, 2022, February 26, and April 13, 2023, were created by the attending physician. The visit for February 26 was not signed or locked, the visit on April 13, was not locked, and the visit on December 12, 2022, was not signed or locked and showed it was revised by a facility employee identified as a registered nurse. An additional medical visit created and revised by the physician's assistant dated March	F 0842		

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F 0842 SS=E	Continued from page 29 3, 2023, was not locked in the electronic record. In an interview with the Nursing Home Administrator and Director of Nursing on April 26, 2023, at 1:10 PM the Director of Nursing confirmed the medical visit assessments were not "complete" in the resident's electronic medical record as noted above, and a registered nurse had the ability to access and revise the medical provider's medical visit documentation for Resident 3. Clinical record review for Resident 2 revealed that a physician's assistant assessed them on February 3, 2023, and the physician assessed them on April 10, 2023. Both visits indicated "in progress" at the time of the survey and neither visit was locked or signed off as complete and finalized in the facility's electronic record. Clinical record review for Resident 5 revealed medical visits in the assessment section of the resident's electronic clinical record dated December	F 0842		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0842 SS=E	Continued from page 30 9, 2022, March 6, 2023, and April 13, 2023, were created by the physician. The December 9, 2022, and April 13, 2023, visits indicated "in progress" at the time of the survey. The visits were signed by the physician, but not locked and finalized in the facility's electronic record. The March 6, 2023, physician's visit indicated that it was "in progress" at the time of the survey and was not locked or signed off as complete and finalized in the facility's electronic record. An additional medical visit created by the physician's assistant dated March 3, 2023, was signed but not locked or finalized in the electronic record. Clinical record review for Resident 11 revealed that a physician's assistant assessed them on December 30, 2022. The visit indicated "in progress" at the time of the survey. The visit was signed by the physician's assistant, but not locked and finalized in the facility's electronic record. A March 8, 2023, physician visit indicated that it was "in progress" at the time of the survey and was not locked or signed off as complete and finalized in the facility's	F 0842		

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F 0842 SS=E	Continued from page 31 electronic record. Clinical record review for Resident 19 revealed that a physician's assistant assessed them on November 28, 2022. The visit indicated "in progress" at the time of the survey. The visit was not locked and/or signed off as complete and finalized in the facility's electronic record. A January 13, 2023, physician's assistant visit revealed that it was "in progress" at the time of the survey. The visit was signed by the physician's assistant, but not locked and finalized in the facility's electronic record. This surveyor reviewed the above information during an interview on April 27, 2023, at 10:10 AM with the Director of Nursing. The Director of Nursing acknowledged that the resident's records were not complete. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(5) Nursing services	F 0842		

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F 0881 SS=D		F 0881		

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F 0881 SS=D	Continued from page 33 483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 0881	Wound on resident 19's left heal has been treated per physician instructions and has been monitored. After the initial wound culture, physician discontinued cephalexin and started doxycycline. Physician also added ciprofloxacin. Resident 19 is, and has been, receiving weekly wound treatment to the left heal. Physician assesses the wound during each treatment. Physician will enter progress note for this wound by 05/13/2023. The Infection Control Preventionist wrote a new policy specifying how culture and sensitivities get reported the ordering physician and how and when the Infection Preventionist is notified. Licensed nursing staff will be educated regarding the proper procedure for notifying the Infection Preventionist about culture and sensitivity results. Reporting of culture sensitivities has	Completion Date: **05/26/2023** Status: **APPROVED** Date: **05/12/2023**

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	395448	A. BLDG: __00_____ B. WING: _____	04/28/2023

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F 0881 SS=D	Continued from page 34	F 0881	been added as a Quality Indicator (QI) of the Quality Assurance program. The Infection Preventionist will monitor reporting of culture and sensitivities, date resulted, and date received and will report results in the monthly Quality Assurance meeting. The Infection Preventionist will continue to monitor reporting of culture sensitivities, date resulted, and date received until 100% compliance with the new culture and sensitivities reporting policy is attained and maintained for three (3) consecutive months.	

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F 0881 SS=D	Continued from page 35 Based on clinical record review and staff interview, it was determined that the facility failed to maintain an antibiotic stewardship program that includes a system to effectively monitor antibiotic usage for one of one resident reviewed (Resident 19). Findings include: Clinical review for Resident 19 revealed a physician's order dated April 10, 2023, for staff to complete a wound culture of the left heel. Review of Resident 19's laboratory final report dated April 13, 2023, revealed that her left heel wound grew many Proteus Mirabilis organisms (an infection). Further review revealed that the identified organism was resistant to treatment with Ciprofloxacin (an antibiotic). On April 13, 2023, the physician ordered Ciprofloxacin 250 milligrams by mouth twice daily for a skin infection for 10 days. Review of Resident 19's April 2023 MAR (medication	F 0881		

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F 0881 SS=D	Continued from page 36 administration record, a form to document medication administration) revealed that staff administered Ciprofloxacin twice daily from April 13, 2023, at 9:00 PM to April 23, 2023, at 9:00 AM. There was no evidence that staff identified that Resident 19's skin infection was resistant to Ciprofloxacin prior to or throughout the medication administration. The surveyor reviewed this information during an interview with the Nursing Home Administrator and the Director of Nursing on April 27, 2023, at 1:00 PM. 28 Pa. Code 211.2(a) Physicians services 28 Pa. Code 211.10 (a) Resident Care Policies 28 Pa. Code 211.12 (a)(c)(1)(3)(5) Nursing services	F 0881		

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P 0400	§ 201.14(a) Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION is not met as evidenced by:	P 0400	On the DOH survey it was found that a representative from Lab was not present at IC meetings from April 2022 through present. The Lab manager was present at the most recent IC meeting which was held 4/26/2023. The Lab manager will be made aware that lab representation is required at IC meetings at least quarterly. The Lab manager will monitor Lab attendance of Infection Control meetings and will report at QA quarterly. The Lab manager will continue to monitor Lab attendance at the IC meetings and will report until attendance is consecutive for 4 quarters. After 4 consecutive quarters QA reporting can be moved to random.	Completion Date: **05/19/2023** Status: **APPROVED** Date: **05/10/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

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P 0400	Continued from page 1 Based on review of infection control meetings and staff interview, it was determined that the facility did not comply with the requirements of the Act 52 Infection Control Plan. Findings include: The Act 52 Infection Control Plan, states that a health care facility should develop and implement an internal infection control plan that should be established for the purpose of improving the health and safety of residents and health care workers and should include a multidisciplinary committee including a representative from each of the following, if applicable to the specific health care facility: (i) Medical staff that could include the chief medical officer or the nursing home medical director (ii) Administration representatives that could include the chief executive officer, the chief financial officer, or the nursing home administrator (iii) Laboratory personnel (iv) Nursing staff that could include a director of	P 0400		

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P 0400	Continued from page 2 nursing or a nursing supervisor (v) Pharmacy staff that could include the chief of pharmacy (vi) Physical plant personnel (vii) A patient safety officer (viii) Members from the infection control team, which could include an epidemiologist. (ix) The community, except that these representatives may not be an agent, employee, or contractor of the health care facility. Review of infection control meeting minutes and attendance records from June 2022 through March 2023, revealed the infection control committee meets monthly. There was no evidence laboratory personnel attended any of the meetings in the time frame reviewed. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on April 27, 2023, at 2:00 PM.	P 0400		

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P 0605	§ 201.22(e) Prevention, control and surveillance of TB. (e) The 2-step intradermal tuberculin skin test shall be the method used for initial testing of residents and employes. If the first test is positive, the person tested shall be considered to be infected. If the first test is negative, a second test should be administered in 1--3 weeks. If the second test is positive, the person tested shall be considered to be previously infected. If the second test result is negative, the person is to be classified as uninfected. This REGULATION is not met as evidenced by:	P 0605	A 2-step intradermal tuberculin skin test shall be verified on every employee upon hire. If the first test is negative the next test will be administered in 1-3 weeks. The PPD administration dates will be monitored by the Employee Health Nurse. It will be verified that the 2-Step test was administered in the appropriate time period of 1-3 weeks. The Employee Health Nurse will monitor the dates of PPDs and report them, monthly in QA. Appropriate PPD administration will continue to be monitored and reported in QA consecutively for 6 months, and then can be moved to random.	Completion Date: **05/19/2023** Status: **APPROVED** Date: **05/10/2023**

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P 0605	Continued from page 4 Based on employee's personnel file review and staff interview, it was determined that the facility failed to complete a two-step tuberculosis (TB) test upon hire for two of five employees reviewed (Employees 3 and 4). Findings include: Review of Employee 3's, housekeeping, personnel file revealed that the facility hired them on December 27, 2022. The facility completed a single TB test on June 9, 2022, and another single TB test on October 11, 2022. There was no documentation that the facility completed a two-step TB test prior to the June 9, 2022, TB test or obtained verification of Employee 3's TB status upon hire. Review of Employee 4's, maintenance, personnel file revealed that the facility hired them on January 24, 2023. The facility completed a single TB test on May 2, 2022, and another single TB test on January 3, 2023. There was no documentation that the facility completed a two-step TB test prior to the	P 0605		

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P 0605	Continued from page 5 May 2, 2022, TB test or obtained verification of Employee 4's TB status upon hire. The surveyor reviewed this information during an interview with the Director of Nursing on April 28, 2023, at 10:50 AM.	P 0605		

Certified End Page

BUCKTAIL MEDICAL CENTER

STATE LICENSE NUMBER: 549602

SURVEY EXIT DATE: 04/28/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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